Complete Summary

GUIDELINE TITLE

Adapting your practice: treatment and recommendations for homeless patients with chlamydial or gonococcal infections.

BIBLIOGRAPHIC SOURCE(S)

Bonin E, Brammer S, Brehove T, Hale A, Hines L, Kline S, Kopydlowski MA, Misgen M, Obias ME, Olivet J, O'Sullivan A, Post P, Rabiner M, Reller C, Schulz B, Sherman P, Strehlow AJ, Yungman J. Adapting your practice: treatment and recommendations for homeless patients with chlamydial or gonococcal infections. Nashville (TN): Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc.; 2003. 30 p. [19 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Sexually transmitted diseases in homeless adults, adolescents, children, and infants:

- Chlamydia
- Gonorrhea

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Prevention
Treatment

CLINICAL SPECIALTY

Family Practice
Infectious Diseases
Internal Medicine
Obstetrics and Gynecology
Pediatrics

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments
Speech-Language Pathologists
Students
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

To recommend adaptations in standard clinical practice to improve health outcomes for homeless adults, adolescents, children, and infants with chlamydial or gonococcal infections and to prevent transmission of these organisms

TARGET POPULATION

Homeless young adults, adolescents, infants, and children with chlamydia or gonorrhea

INTERVENTIONS AND PRACTICES CONSIDERED

Adults and Adolescents

Diagnosis/Evaluation

1. History including sexual practices, sexual abuse/ exploitation, prior sexually transmitted diseases (STDs), reproductive health/contraception, developmental level/ readiness for behavioral change (if warranted), number and geographic location of sex partners
2. Physical examination, including preventive care (breast, pelvic, testicular exams), pharyngeal and rectal exams (if pertinent), with particular sensitivity to fears/concerns of patients with history of sexual abuse

3. Diagnostic tests including nucleic acid amplification tests, culture, direct fluorescent antibody (DFA), enzyme immunoassay (EIA), and nucleic acid probe (NAP) for Chlamydia trachomatis and Neisseria gonorrhoeae; screening for other STDs and vaginitis; urine test for pregnancy; Pap smear

Management/Treatment

1. Education and self-management, including educating patients about risk reduction, importance of seeking medical care immediately when symptoms occur, dispelling myths about home "remedies" against STDs, facilitating access to housing/social services, helping patient develop safety plan if physical/sexual abuse is suspected
2. Medications using simple regimen (single-dose observed therapy when possible), presumptive treatment pending test results (if permissible and safe); hepatitis A and B vaccines for at-risk patients, low threshold of suspicion for drug-resistant organisms among mobile patients with multiple/ unknown sex partners
3. Recognizing and managing associated problems/ complications such as rape, pregnancy, pelvic inflammatory disease, Reiter's Syndrome, more florid disease due to delayed care/nonadherence/loss to follow-up, psychological factors affecting sexual behavior/adherence, and possible legal barriers to medical care/confidentiality for unaccompanied minors
4. Follow-up, including documenting contact information at every visit; partner identification, notification, treatment; use of incentives, peer-led prevention/intervention groups and positive patient-provider relationships to promote return visits

Infants and Children under 3 Years of Age

Diagnosis/Evaluation

1. History including living conditions, sexual history of mother, treatment of STD in parent/partner, prenatal/neonatal care
2. Physical examination (no adaptation of standard guidelines)
3. Diagnostic tests for chlamydia/gonococcal conjunctivitis or pneumonia: cell culture; non-deoxyribonucleic acid (non-DNA) tests (non-DNA are not acceptable if child abuse is suspected); nucleic acid amplification tests

Management/Treatment

1. Patient education/self-management including educating parent about signs and symptoms of chlamydia and gonorrhea; explaining that all infected family members must be treated to prevent transmission and complications
2. Medications, such as antibiotics with minimal gastro-intestinal side effects; presumptive treatment without lab results if high suspicion of infection
3. Recognizing and managing associated problems/complications such as diarrhea (side effect of antibiotics), lack of prenatal/post-partum care, physical/sexual abuse of parent as an adult or in childhood, lack of financial resources, lack of consistent follow-up
4. Follow-up, including outreach to facilitate return visits, test of cure if treatment regimen not completed

Children Not Consenting to Sex

Diagnosis/Evaluation

1. History including living situation/household members, unwelcome sex, child safety/possibility of sexual abuse/risk of loss to follow-up, psychosocial evaluation of family unit
2. Physical examination including general exam (height, weight, head circumference, etc, in accordance with early and periodic screening, diagnosis and treatment (EPSDT) screening requirements) and forensic evaluation for sexual abuse/assault (if suspected)
3. Diagnostic tests such as cell culture (required if sexual assault is suspected); no adaptation of standard guidelines

Management/Treatment

1. Education/self-management including prevention (identifying "safe haven" for child when mother is absent), developing a safety plan for abused parent or child, explaining mandatory abuse reporting requirements
2. Medications (no adaptation of standard guidelines)
3. Recognizing and managing associated problems/ complications, such as sexual abuse/behavioral health problems of parent, fear of authorities, increased risk of abuse in shelters, unsafe childcare alternatives, loss of child to state custody
4. Follow-up, including referral of child to child protective services (if warranted), referral of parent for counseling, providing social support to parent losing custody of child

MAJOR OUTCOMES CONSIDERED

- Incidence/prevalence of chlamydial/gonococcal infections in homeless populations
- Use of barrier devices by homeless males and females who are sexually active
- Access to sex education and psychosocial supports for homeless youth
- Access to mental health care/addiction treatment and supportive housing for persons with behavioral health disorders
- Health disparities between homeless and general U.S. populations

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Searches of MEDLINE, SocABS, PsycInfo databases were performed. Bibliographies compiled by the Bureau of Primary Health Care´s Homeless Information Resources Center were also searched.

NUMBER OF SOURCE DOCUMENTS

This guideline is adapted from three primary sources.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Network Steering Committee and other primary health care providers, representing Health Care for the Homeless (HCH) projects across the United States, devoted several months during 2002-03 to developing adapted clinical guidelines for the treatment of chlamydial or gonococcal infections in homeless patients. The adaptations reflect their collective experience in serving homeless people with sexually transmitted diseases (STDs) and alert clinicians to the strong association between STDs and sexual abuse in this population.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Clinical Validation-Pilot Testing
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline developer's Advisory Committee identifies, in the original guideline document, the clinicians who reviewed and commented on the draft recommendations prior to publication, including experienced Health Care for the Homeless practitioners and medical experts in adolescent and pediatric care. The guideline was field tested by clinicians in designated Health Care for the Homeless projects during the summer of 2003. Evaluation criteria included clarity, flexibility and ease of use; relevance to the care of homeless clients or those at risk of becoming homeless; inclusion of strategies to promote outreach and case management and ensure follow-up; sufficiently detailed to ensure that similar practitioners would offer similar treatment in the same circumstances; and sufficiently complete to enable new clinicians to use them for homeless clients. Evaluators found that the guideline met all of these criteria and recommended future development of "short forms" of this and other adapted clinical guidelines to facilitate use in a variety of clinical settings.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Adults and Adolescents

Diagnosis and Evaluation

History

- Sexual practices Obtain detailed history of sexual practices at first visit (Nusbaum & Hamilton, 2002). Responding to questions may influence behavior even if patient does not return for follow-up. Discuss medical confidentiality and its limits (e.g., in cases of child abuse, threat to self or others) with patient. Determine if patient has exchanged sex for money or drugs and whether s/he remembers what happened and with whom. Use written questions so patient knows it is standard procedure to ask them. Ask same questions of both males and females in a nonjudgmental way:
    - How old when had first welcome sexual experience, one that was not forced on you?
    - How many sex partners in lifetime? past year?
    - Were sex partners male? female? both?
    - Partner risks: human immunodeficiency virus (HIV) positive? Are partners having sex with other men and/or women? Is partner a drug dealer?
    - Traded sex for drugs, money, place to stay?
    - Condom use/barrier methods, dental dams, etc?
    - Vaginal intercourse? Oral intercourse? Anal intercourse? Give and/or receive?
    - Use toys, dildos, vibrators?
- Sexual abuse Ask whether patient has been forced to have sexual intercourse against his/her will. Assess for violence, abusive relationships, and patient safety (e.g., whether knowledge of sexually transmitted diseases [STD] may precipitate abuse against patient or partner). Evaluate need to

report assault/abuse. Ask if patient wants evidence collected to pursue legally. In the case of minors, disclosed sexual abuse histories must be reported to child protective services. Be knowledgeable about mandatory reporting requirements regarding consensual sexual activity and abuse in your state, and explain them to patient. (For a summary of state reporting requirements for domestic violence or adult abuse, see: http://endabuse.org/statereport/list.php3. To look up statutory requirements for reporting child abuse in your state, see: http://nccanch.acf.hhs.gov/general/statespecific/index.cfm.)

- Exploitation Consider possible exploitation of patient, especially if mental illness or developmental disability is suspected. (Partner´s refusal to use a condom may be a form of exploitation.) Substance abuse and "survival" sex also increase risk for sexually transmitted diseases. Realize that adolescents may not understand or acknowledge that they are being exploited when exchanging sex for food, shelter, or drugs.
- Prior STDs Ask about history of STDs in both male and female patients. Infestations that are commonly sexually transmitted, such as lice and scabies, pose special challenges for homeless people, whose use of showers and laundry facilities may be limited by lack of funds, facilities, or spare clothing.
- Reproductive health Obtain gynecological history including best possible menstrual history for females. Ask what method of contraception is used; if none, explore interest in pregnancy prevention.
- Readiness to change Assess patient´s developmental level and readiness to change sexual behaviors. Find out what motives are for engaging in particular behaviors.
- Partner history Always ask whether partner needs to be treated. Also inquire about new or casual encounters. Transience of homeless people and lack of familiarity with sex partners complicates partner notification. Try to identify geographic areas where patient and partner(s) have been to determine risk for drug-resistant organisms.

Physical Examination

- Preventive care For female patient, do breast exam with pelvic exam to address preventive as well as acute care needs. For male patient, include testicular exam. Anticipate shyness and anxiety about sexual norms in adolescents; conscientiously respect their privacy and need for control. Eliminate rectal exam if not pertinent to clinical presentation.
- Sexual abuse Be sensitive to concerns, fears, and safety needs of patients with a history of sexual abuse, who may be reluctant to have a rectal, pharyngeal, or pelvic exam. Consider using an assistant for exams of unclothed patients and clothed patients who seem emotionally disturbed, recognizing high prevalence of paranoia, delusions, sexual trauma, and posttraumatic stress disorder (PTSD) among homeless people.
- Refused pelvic exam Consider empiric treatment if patient has history of exposure (e.g., when partner has been diagnosed with chlamydial or gonococcal infection). Consider obtaining urine ligase chain reaction (LCR) for Chlamydia trachomatis and Neisseria gonorrhoeae in lieu of pelvic exam. Consider self-administered vaginal swab for saline and potassium hydroxide (KOH) preparations when genital exam is refused.

- Pharyngeal and rectal exams Suspect chlamydial or gonococcal infection if pharyngeal and/or rectal symptoms are present and patient has history of exposure.

Diagnostic Tests

- Chlamydia/gonorrhea. Screen for C. trachomatis and N. gonorrhoeae with every female pelvic examination if cervix is present, whether patient is symptomatic or not. (Males more likely to be symptomatic.) Use most highly sensitive and accurate screening method available and affordable, recognizing that time required to obtain lab reports is also an issue because of follow-up concerns.
    - Nucleic Acid Amplification tests. Ligase chain reaction (LCR), polymerase chain reaction (PCR), transcription mediated amplification (TMA), and strand displacement amplification (SDA) are preferred methods for diagnosis and screening. Advantages: highest sensitivity and specificity for chlamydial and gonococcal infections with both genital and urine specimens, and do not require invasive exam. Disadvantages: tests are costly and lab results may take up to two weeks. Treat empirically pending lab results. Urine LCR now preferred for males.
    - Culture can still be used if more sensitive, less invasive, more convenient diagnostic tests are not available or affordable. Bacterial culture test for gonorrhea is cheap and highly specific, but requires special handling and incubation. Cell culture for chlamydia no longer in common use, except in cases of child abuse or sexual assault. Culture is the only acceptable diagnostic test for medicolegal purposes. Treat empirically pending culture results.
    - Other diagnostic tests. Direct fluorescent antibody (DFA), enzyme immunoassay (EIA), and nucleic acid probe (NAP) are widely available, though less sensitive for both gonorrhea and chlamydia, but can only be used with genital specimens, making exam necessary.
- Vaginitis Consider obtaining specimen for wet mount on site, if possible, to screen for co-occurring trichomonas or bacterial vaginosis, and assess degree of acute inflammation.
- Other STDs Screen for other sexually transmitted diseases if feasible, including human immunodeficiency virus (oral HIV testing optimal), syphilis (rapid plasma reagin [RPR] or venereal disease research laboratory [VDRL] test), and hepatitis B. The guideline developers recommend wide-based screening within financial means and patient willingness to be screened.
- Pregnancy If any suspicion of pregnancy, do urine testing. All pregnant women should be screened for both chlamydia and gonorrhea.
- Papanicolaou (Pap) smear While results may be obscured by or reveal atypia attributable to inflammation, this may be a rare opportunity to uncover or prevent a serious condition in a homeless woman who would not otherwise be screened.

Plan and Management

Education, Self-Management

- Risk reduction Assist client to identify and reduce personal risks for sexually transmitted disease. Emphasize risk of STDs with unprotected sex. Use a risk reduction approach; promote use of condoms and reduction in number of sexual partners. Employ interactive counseling focused on preventing transmission of disease, including description of risky behaviors and preventive methods. Counseling should be nonjudgmental, client-centered, and appropriate to client´s age, gender, sexual orientation, and developmental level. For patients with substance abuse problems, offer referral for treatment and counseling; for injection drug users, offer access to clean needles when available.

  Explain that no screening test result warrants unprotected sex. Encourage use of condoms and provide information on availability of condoms, either on-site or elsewhere. Learn techniques that sex workers use to protect themselves (e.g., "cheeking" a condom for oral sex). If high-risk sexual behavior is perceived as necessary to meet basic survival needs, try to engage patient for services and find another way of meeting underlying needs. If high-risk behavior is used to obtain a drug on which patient is dependent, continually offer detoxification/substance abuse treatment as an alternative.

- Medical care Educate patient about importance of seeking medical care immediately when symptoms occur. Explicitly discuss possibility of having an infection without symptoms. If patient is at risk, stress that regular screening for STDs is part of reproductive health.
- Dispel myths about home remedies or protections against STDs with cultural sensitivity. For example, symptomatic males may try to cure themselves by scrubbing genitalia with bleach, lemon juice, alcohol, earth, aloe vera, or Vicks Vaporub. Some believe in the cleansing power of urine and apply it to sores and in eyes for conjunctivitis. These "remedies" are especially popular in some areas of Mexico. Many patients believe that STDs can be contracted from dirty toilets and common showers in shelters, that oral contraceptives protect against sexually transmitted disease, and that "you can tell who is likely to have an STD; if you don´t see a sore, your partner isn´t infected." Explain that most STDs are asymptomatic, but can still have negative consequences; that STDs are infections associated with particular behaviors, not punishments for moral failings.
- Case management Provide case management to assure access to housing and other social services, recognizing that these interventions are also effective forms of STD prevention.
- Safety Help patient develop a safety plan if interpersonal violence/sexual abuse is suspected; explain adult and child abuse reporting requirements in your state.

  (For a summary of state reporting requirements for domestic violence or adult abuse, see: http://endabuse.org/statereport/list.php3. For information about mandatory reporting requirements for child abuse in all 50 states, see: http://nccanch.acf.hhs.gov/general/statespecific/index.cfm

Medications

- Simple regimen. Simplify treatment regimen; use single-dose observed therapy whenever possible for gonorrhea, chlamydia, and syphilis. Sometimes

multi-dose, extended regimens cannot be avoided (e.g., in males with epididymitis).

- Presumptive treatment. Treat patient and partner empirically pending lab results, even if partner is not seen in clinic, if this can be done safely, and if regulations/clinic policies permit. Design treatment regimen to cover common, co-occurring STDs.
- Hepatitis B virus (HBV) and hepatitis A virus (HAV) Recognize that some homeless people are at high risk for hepatitis B and/or hepatitis A, especially intravenous drug users and their sexual partners (HBV), and men having sex with men (HAV). Assure that at-risk patients are immunized. For those who have been partially vaccinated, resume schedule whenever possible.
- Resistant organisms Recognize higher risk for drug-resistant organisms (e.g., quinolone-resistant N. gonorrhea) among highly mobile homeless patients with multiple, unknown sex partners. For patients unresponsive to standard treatment, consider non-gonococcal, non-chlamydial urethritis (e.g., ureaplasma and mycoplasma), which frequently respond to longer courses of macrolide antibiotics or doxycycline.

Associated Problems/Complications

- Rape including unrecalled rape that occurred when patient was under the influence of alcohol and/or drugs
- Pregnancy including ectopic pregnancy (Always offer contraceptive options.)
- Pelvic Inflammatory Disease (PID) – a serious complication of untreated STDs frequently seen in homeless women, which can result in infertility
- Reiter´s Syndrome – inflammatory arthritis which can be triggered by chlamydia or other infectious agents
- More florid disease. Homeless people often do not seek medical help until their disease is advanced and symptoms are florid. Poor hygiene, mental illness, substance abuse, and "survival sex" increase their risk for sexually transmitted diseases.
- Nonadherence/loss to follow-up People who are homeless may place a higher priority on meeting basic needs than on obtaining needed health care or following through with prescribed treatment. Substance use disorders and mental illness further complicate adherence and follow-up. (Always approach patient encounter with a nonjudgmental attitude.)
- Psychological factors Recognize that lack of self-esteem or assertiveness skills, emotional/psychological needs, addictions, developmental disabilities, partner attitudes, and/or developmental stage may affect patient´s sexual behavior and adherence to a plan of care. Homeless adolescents and youth are often developmentally less advanced than peers of same chronological age; concrete thinking predominates over abstract reasoning skills, according to providers who are experienced with this population. Homeless adults with mental illness or chronic substance use may have impaired reasoning and delayed social development that causes them to act like young adolescents. When discussing behavior change with these patients, focus on immediate concerns rather than possible future consequences.
- Legal considerations. Many homeless youth are emancipated minors. Be aware of possible legal barriers to medical care of unaccompanied youth and limits of patient confidentiality. These vary from state to state (English et al., 2002).

Follow-Up

- Contact information. At every visit, seek contact information for patient, family member or friend with a stable address, shelter where patient is currently staying, patient´s case manager and health care providers, including telephone/cell phone numbers and mailing/email addresses.
- Outreach. Use outreach workers for partner identification and to bring hard-to-reach individuals (especially adolescents) to the clinic. Provide diagnostic testing (e.g., urine screening) and treatment at outreach sites whenever possible.
- Partner notification. Work with local public health department to facilitate partner identification, notification, and treatment.
- Incentives. Use incentives (phone cards, bus tokens, hygiene kits, free condoms, socks, fast food coupons) to encourage patients to return for lab results.
- Peer-led groups. Initiate peer-led STD prevention/intervention groups; include lunch to attract participants.
- Provider-patient relationship. Build positive, encouraging relationships with clients to increase likelihood of return for follow-up care.

Infants and Children under 3 Years of Age

Diagnosis and Evaluation

History

- Living conditions. Ask parent where family is living – on the street? in a shelter or motel room? in their car? staying with friends or relatives? In some cases, homelessness is a risk factor for sexually transmitted diseases; chlamydia and gonorrhea are commonly reported STDs in homeless patients.
- Sexual history of mother. Ask mother about her sexual behaviors and partner(s) in a nonjudgmental way. (See recommendations for chlamydial/gonococcal infections in adults and adolescents.)
- Access to care. Inquire about parental/partner treatment for STDs.
- Prenatal/neonatal care. Ask mother how many prenatal care visits she had and where child was delivered. Lack of prenatal care is a risk factor for neonatal chlamydia. Assess likelihood of ophthalmia prophylaxis to prevent maternal transmission of N. gonorrhoeae to neonate.

Physical Examination

No adaptation of standard guidelines recommended.

Diagnostic Tests

For chlamydial/gonococcal conjunctivitis or pneumonia in an infant or child under age three years:

- Cell culture is preferred for conjunctival, pulmonary specimens; more sensitive and specific than non-DNA tests. Collect conjunctival cells, not just

exudates. Tissue culture of nasopharynx if C. trachomatis pneumonia is suspected. (Culture required if child abuse is suspected.)

- Non-DNA tests. Direct fluorescent antibody (DFA), enzyme immunoassay (EIA), or nucleic acid probe may be used for conjunctival specimens. Only DFA is used for nasopharyngeal specimens. These tests are less sensitive than cell culture. (Not acceptable if child abuse is suspected because false-negatives and false-positives may occur.)
- Nucleic Acid Amplification tests. Ligase chain reaction (LCR), polymerase chain reaction (PCR), transcription mediated amplification (TMA), and strand displacement amplification (SDA) tests are not used with conjunctival, pulmonary, or nasopharyngeal specimens, nor are they admissible for medicolegal purposes if child abuse is suspected, although they are more sensitive, less invasive, and more convenient than other diagnostic tests.

Plan and Management

Patient Education/Self-Management

- Symptoms. Educate parent about signs and symptoms of chlamydial and gonococcal infections in infants. Conjunctivitis (red, sticky eyes) may be a symptom of either type of infection; cough with tachypnea is a symptom of neonatal chlamydial infection but not of gonococcal infection. Use written educational materials only if you are sure parent can read and understand them. Inquire nonjudgmentally about parent´s literacy level in the language in which materials are written.
- Treatment. Explain that infant, parent, and any infected partner(s) must be treated to prevent transmission and complications of infection. Tell parent that untreated chlamydial infections in children will lead to serious health problems affecting their eyes, ears, and lungs.

Medications

- Gastrointestinal (GI) upset Prefer antibiotic with minimal gastrointestinal irritation. Infants often get candidal diaper dermatitis from diarrhea secondary to this side effect. Diarrhea is a more serious issue with homeless patients. Make provisions for extra diapers and a place for parent to cleanse infant.
- Presumptive treatment. Treat empirically without lab results if there is high suspicion of infection, recognizing that patient may not return for follow-up.

Associated Problems/Complications

- Diarrhea as a side effect of antibiotics is more difficult for homeless families to manage because of limited access to diapers and facilities for cleansing child. Maintaining adequate hydration can also be a problem if fluids are not readily available.
- Lack of prenatal/post-partum care, indicating need for case management and social supports for mother
- Physical/sexual abuse of parent as an adult and/or in childhood
- Lack of financial resources for medications, transportation, quality daycare
- Lack of consistent follow-up secondary to mobility

Follow-Up

- Outreach. Use outreach workers to locate infant for appropriate follow-up.
- Test of cure. If mother says infant did not complete treatment regimen or missed a few days, repeat chlamydial culture and resume treatment. Greater likelihood of poor adherence and unpredictable follow-up increases risk of unresolved infection in homeless infants.

Children Not Consenting to Sex

Diagnosis and Evaluation

History and Assessment

- Living situation. Ask where patient is living and with whom. Don´t assume current family make-up has always been the same. Establish rapport with parent.
- Unwelcome sex. In a separate interview, ask child about being touched against his/her will or being forced to have sexual intercourse.
- Child safety. Carefully assess for possible sexual abuse. Ask who is participating in childcare, who watches child when parent is busy, who takes child to the bathroom. Ask parent about sexual behaviors of adult caregivers and partners. Don´t assume physical or sexual abuse just because a homeless child has a chlamydial infection. Although a positive chlamydial culture beyond the newborn period indicates "probable" sexual abuse (Reese & Ludwig, 2001), chlamydial infection from perinatal transmission may occur in children up to three years of age. However, a positive gonococcal culture beyond the immediate newborn period is "certain evidence" of sexual abuse (Reese and Ludwig, 2001). Most chlamydial and gonococcal infections in children over age three are from sexual abuse, and for some homeless children, the risk of sexual abuse is high.

  If sexual abuse is suspected, follow your state´s statutory requirements for reporting child abuse. (For information about mandatory reporting requirements in all 50 states, see http://nccanch.acf.hhs.gov/general/statespecific/index; and the National Clearinghouse for Child Abuse and Neglect Information: http://nccanch.acf.hhs.gov. Hotline phone numbers for reporting suspected abuse and neglect are available at http://www.acf.dhhs.gov/programs/cb/publications/rpt_abu.htm.) If provider is unsure whether to report sexual abuse call a local specialist in child abuse, who can usually be found in regional children´s hospitals. (See also: Internet resources for medical practitioners, in the original guideline document.)

- Identify risk of loss to follow-up. Assess risk that family may flee and patient may be lost to follow-up; base decision to refer to child protective services or the police on this assessment.
- Psychosocial evaluation. Evaluate whole family unit, not just the child. Assess for mental stress and history of physical/sexual abuse; if the medical provider cannot do so, refer to someone who can. Assess risks to child from substance abuse/mental illness of a parent or other caregiver.

Physical Examination

- General. Use every patient visit as an opportunity for a general physical examination, including height, weight, head circumference, and other screening recommended by standard clinical guidelines (e.g., American Academy of Pediatrics guidelines: www.aap.org/policy/paramtoc.html) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services required for children on Medicaid. (See: Early and Periodic Screening, Chapter 05, State Medicaid Manual www.cms.hhs.gov/manuals/45_smm/pub45toc.asp.) Balance comprehensive care with meeting child´s acute needs.
- Forensic evaluation. Sexual abuse/assault evaluations are most appropriately provided at centers experienced in forensic interviewing and evaluation that are equipped to collect evidence and strictly maintain the chain of evidence. Examination provided in a clinic within 24 hours of a sexual assault (36 hours at most) precludes collection of forensic evidence. Once there is a reasonable suspicion of sexual assault or molestation of a child, medical provider can be most useful by facilitating referral of child through child protective services or the police.

Diagnostic Tests

- Cell culture is required if sexual abuse is suspected. For medical issues, rapid tests (e.g., nucleic acid amplification tests) are acceptable, but for legal issues the only sanctioned documentation of gonococcal or chlamydial infection is a culture.

  No adaptation of standard guidelines recommended.

Plan and Management

Education/Self-Management

- Prevention. Ask if there is a "safe haven" for child when mother is not present. Investigate availability of respite nurseries.
- Abuse of parent. Develop a safety plan for abused parent to break the cycle of domestic/interpersonal violence. Know the mandatory reporting requirements in your state for adult abuse. (For a summary of state reporting requirements for domestic violence or adult abuse, see: http://endabuse.org/statereport/list.php3).
- Abuse of child. Offer support to parent whose child has been abused by someone else. Explain that social worker´s role is to help family cope with this situation. Be knowledgeable about mandatory child abuse reporting requirements in your state and explain them to the parent.

  (To look up statutory requirements for reporting child abuse in your state, see: http://nccanch.acf.hhs.gov/general/statespecific/index.cfm).

Medications

No adaptation of standard guidelines recommended.

Associated Problems/Complications

- Sexual abuse of parent. Mental health support may be required for parental depression or posttraumatic stress disorder (PTSD) secondary to prior sexual abuse. Part of treating child is helping parent to avoid future physical or sexual abuse as well. Mother may need to be transferred to a safe place for protection from continued abuse.
- Substance abuse. Parents with a history of drug abuse may fear that child will be taken away from them if sexual abuse is reported to child protective services.
- Fear of authorities. Homeless people may also be nervous about any interaction with authorities who may have treated them badly in the past. Some parents also fear being reported to immigration officials.
- Childcare. Homeless parents without access to childcare often leave their children with strangers.
- Housing. In some shelters, single men, families, and children all stay in same room. This increases risk for sexual abuse. Formerly incarcerated perpetrators of sexual abuse who become homeless when released from jail may interact with families in shelters and at food distribution sites.
- Loss of child custody. Parent who loses custody of child may also lose access to shelter and benefits, but can´t get child back until housing is obtained.

Follow-Up

- Referral of child. If there is evidence of sexual abuse, refer child to child protective services (CPS) and for specialized assessment and counseling. Emphasize that CPS can be a support system for parents, to help them obtain what they need for their child.
- Referral of parent. Refer mother to counseling for prior sexual abuse.
- Social support. Specify shelter options and other resources for parent who loses child to state custody.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

This is a guideline adapted from the following sources:

- CDC. Sexually Transmitted Diseases Treatment Guidelines, 2002: 1–7, 30–41, 69–74: www.cdc.gov/mmwr/PDF/RR/RR5106.pdf.
- CDC. Chlamydia in the United States, April 2001: www.cdc.gov/std/Chlamydia/STDFact-Chlamydia.htm

- CDC. Neisseria gonorrhoeae, February 2000: http://www.cdc.gov/ncidod/dastlr/gcdir/gono.html

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Improved patient adherence to treatment and improved patient outcomes
- Improved quality of care and quality of life for homeless patients with sexually transmitted diseases
- Reduced transmission of chlamydia, gonorrhea, and other sexually transmitted infections including HIV/AIDS

POTENTIAL HARMS

Diarrhea as a side effect of antibiotic treatment for chlamydia and gonorrhea, which is more difficult for homeless families to manage because of limited access to restrooms, bathing facilities and diapers.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The information and opinions expressed in the guideline are those of the Advisory Committee for the Adaptation of Clinical Guidelines for Homeless Patients with chlamydia and gonorrhea, not necessarily the views of the U.S. Department of Health and Human Services, the Health Resources and Services Administration, or the National Health Care for the Homeless Council, Inc.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

This guideline has been distributed to 161 Health Care for the Homeless (HCH) grantees across the United States and to several academic programs that train primary care providers. These and other recommended clinical practice adaptations to optimize care for homeless persons are also being used in workshops at national and regional conferences including the Health Disparities Collaborative Learning Sessions and the National HCH Conference sponsored by the Bureau of Primary Health Care/HRSA/HHS).

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Bonin E, Brammer S, Brehove T, Hale A, Hines L, Kline S, Kopydlowski MA, Misgen M, Obias ME, Olivet J, O'Sullivan A, Post P, Rabiner M, Reller C, Schulz B, Sherman P, Strehlow AJ, Yungman J. Adapting your practice: treatment and recommendations for homeless patients with chlamydial or gonococcal infections. Nashville (TN): Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc.; 2003. 30 p. [19 references]

ADAPTATION

This is a guideline adapted from the following sources:

- CDC. Sexually Transmitted Diseases Treatment Guidelines, 2002: 1–7, 30–41, 69–74: www.cdc.gov/mmwr/PDF/RR/RR5106.pdf.
- CDC. Chlamydia in the United States, April 2001: www.cdc.gov/std/Chlamydia/STDFact-Chlamydia.htm
- CDC. Neisseria gonorrhoeae, February 2000: http://www.cdc.gov/ncidod/dastlr/gcdir/gono.html

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2003

GUIDELINE DEVELOPER(S)

Health Care for the Homeless (HCH) Clinician's Network - Medical Specialty Society
National Health Care for the Homeless Council, Inc. - Private Nonprofit Organization

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The Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services

GUIDELINE COMMITTEE

Advisory Committee for the Adaptation of Clinical Guidelines for Homeless Patients with Chlamydial and Gonococcal Infections

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The Health Care for the Homeless (HCH) Clinicians' Network has a stated policy concerning conflict of interest. First, all transactions will be conducted in a manner to avoid any conflict of interest. Secondly, should situations arise where a Steering Committee member is involved in activities, practices or other acts which conflict with the interests of the Network and its Membership, the Steering Committee member is required to disclose such conflicts of interest, and excuse him or herself from particular decisions where such conflicts of interest exist.

No conflicts of interest were noted during preparation of this guideline.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the National Health Care for the Homeless Council, Inc. Web site.

Print copies: Available from the National Health Care for the Homeless Council, Inc., P.O. Box 60427, Nashville, TN 37206-0427; Phone: (615) 226-2292

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

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